DOCUMENT RESUME

ED 229 688 CG 016 659

AUTHOR Younger, Robert; And Others
TITLE Working with Chronically Dysfunctional Families.
PUB DATE Mar 82
NOTE 26p.; Paper presented at the Annual Convention of the Southwestern Psychological Association (28th, New Orleans, LA, March 24-27, 1982).
PUB TYPE Reports - Descriptive (141) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Counseling Techniques; *Family Counseling; *Family Problems; Helping Relationship; Mental Disorders; Program Descriptions; Psychotherapy; *Systems Approach
IDENTIFIERS *Disfunctional Families

ABSTRACT

This paper reviews family therapy with chronically dysfunctional families including the development of family therapy and current trends which appear to give little guidance toward working with severely dysfunctional families. A theoretical stance based upon the systems approach to family functioning and pathology is presented which suggests: (1) seeing the family conjointly; (2) surrendering the belief that no change is possible; (3) taking risks; (4) developing creative interventions; (5) allowing families to maintain some symptoms; (6) working with resistance rather than against it; (7) engaging the strongest family members to initiate change; and (8) accepting as success whatever changes occur. These points are illustrated with anecdotal material drawn from both inpatients and outpatients in a major medical complex. (Author/AG)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED229688

Working with Chronically Dysfunctional Families

Robert Younger, Ph.D.

Federal Correctional Institution, El Reno, Oklahoma

Mark W. Cohen, Ph.D.

Veterans Administration Medical Center, Oklahoma City

Jane M. Sullivan, A.C.S.W.

University of Oklahoma Health Sciences Center

Running Head: Family of Chronically Impaired Adults

CG 016659

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

X This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent offic al NIE position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Robert Younger

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Abstract

Family therapy with chronically dysfunctional families was reviewed, including the development of family therapy and current trends which appear to give little guidance toward working with severely dysfunctional families. A theoretical stance was presented based upon the systems approach to family functioning and pathology. This approach suggests: (a) seeing the family conjointly; (b) surrendering the belief that no change is possible; (c) taking risks; (d) developing creative interventions; (e) allowing families to maintain some symptoms; (f) working with resistance rather than against it; (g) engaging the strongest family members to initiate change; and (h) accepting as success whatever changes occur. Points were illustrated with cases drawn from both inpatients and outpatients in a major medical complex.

Treating the Family of Chronically Emotionally Impaired Adults

Over the past decade family therapy has become an important method of explaining and addressing all manner of behavioral/emotional problems. In its beginnings, however, family therapy concentrated almost exclusively upon schizophrenia, specifically the relationship between childhood psychosis and parental communication styles (e.g., Bowen, 1959, 1960; Bateson, Jackson, Haley & Weakland, 1956; Lidz, 1964; Meehl, 1962; Mishler & Waxler, 1968). Neither in this early focus nor in its more general application since, has family intervention adequately addressed the treatment of the severely impaired adult.

Perhaps there are reasons why the early work with schizophrenia concentrated upon childhood forms: (1) the family of the child/adolescent psychotic often presented an intact unit, a living laboratory for study; (2) the developmental process of the disturbance was at a point where familial ties to symptomatology could be spectacularly demonstrated; (3) investigation into the development of schizophrenia in the family offered the real possibility of prevention; and (4) through family therapy a dramatic therapeutic impact with children was attained. Theoretical investigations were coupled with or followed by family therapy case studies, and thus a popular treatment form was born.

While reviewing the seminal works of family therapy and the subsequent burst of energy in this new direction, we observed that studies and interventions with chronic, psychiatrically impaired adults have been rare. The reasons for the wealth of material on children also explain the paucity of material concerning adults: (1) this has not been an easily accessible group; during the 1950's and 1960's, many of the chronic adult population were institutionalized and did not offer easily accessible families for study; (2) by this point in the progress of their disability, prevention and treatment were moot points; and (3) there were more profitable and perhaps more interesting groups with which to work. Thus, family intervention with this population appears to have been attempted only as one of a long line of approaches undertaken with no great expectation of success.

In recent years, however, a number of factors have changed the social climate and cultural view of the adult, chronic psychiatric patient. These changes permit a reappraisal of the worthiness of family therapy with this population. First, the advent and improvement of psychotropic medication as a treatment for these people has lessened the need for long term institutionalization as a measure for controlling their most excessive and socially disruptive symptoms. Indeed, for some time there has been a growing awareness that institutionalization may ultimately have been used more as a means of social control than as treatment (e.g., Becker,

1963; Scheff, 1964, 1966; Szasz, 1961). Secondly, there has been a trend toward significantly lowering the population of state mental hospitals. This trend, related both to a perceived lessening of the need for long term hospitalization and the growing expense of such care, has resulted in more of the adult psychiatric population living in the community for longer periods of time with their families.[1] Third, financial support from both state social service agencies and Federal subsidies (e.g., Supplemental Security Income, VA disability payments, food stamps) as well as treatment alternatives offered by community agencies have allowed the families of the "mentally disabled" adult to remain an intact, albeit marginally functional, unit.[2] This unit, which often sees itself as struggling against a hostile world, provides considerable opportunity for the family therapist. The opportunity for intervention exists not only in regard to ameliorating existing symptoms, but also in preventing social and emotional disability among the children of chronically impaired adults.

This paper will examine issues regarding therapy with families of chronic, severely disturbed adults. It is written with the hope that the reader will revise attitudes about intervention with this population, and develop a realistic approach toward treatment.

The Family: Functional and Dysfunctional

The family is a dynamic, open system comprised of a "complex of components in mutual interaction" (von Bertalanfy, 1974). This

interaction is guided by a set of distinct, albeit unstated, rules devised over time to maintain the functional integrity of the family unit. As indicated by the terms "dynamic" and "open," such a system is a living entity which continually exchanges information both among its component parts (intra-system communication) and between itself and the environment outside the family boundary (inter-system communication).

Maintenance of functional integrity necessitates a modicum of stability. Such stability, often referred to as the homeostatic state, is not fixed at any one place. The steady state is a relative thing. Since the family exists within a fluid setting, it must react to change in order to remain viable. This requirement for change or "capacity for transformation" (Palazzoli et al, 1978) suggests an ability for growth, differentiation and transformation (Kempler, 1974). Thus one may conceptualize stability as a comfortable ordering of interactions which <u>may</u> allow for orderly system change. The goal of therapy is not then to help people arrive somewhere and remain there; rather, the function of family therapy is to assist the family in moving to a place where it is comfortable with the process of change.

Experience has demonstrated to us that most families achieve a functional system with some semblance of what Kempler (1974) terms a higher order union. As the family successfully faces challenges from within and without, most individual members grow

up emotionally, differentiate from the family of origin, and form new family units in a manner which strengthens all involved. For a minority of people, however, such a developmental process cannot adequately occur; in their families, growth and differentiation are met with fear and resistance.

The grossly inadequate family[3] is immobilized by painful memories from the past, fear of the present, and resistance to the future. The past, present, and future are distorted, and true feelings are denied. Survival is all important, and the family attempts to achieve this end by standing still, refusing to change. Separation and individuation are not achieved due to lack of support and fear of abandonment (Jackson, 1958). Intimacy is disavowed for fear of losing one's self to the greater whole. Here, union is defined as the surrendering of self to another (Bowen, 1965a). Rigid rules of thought and behavior maintain a semblance of unity, though in reality the atmosphere is marked by a pervasive sense of unattached aimlessness. Constructive interaction with the external world is minimized; system boundaries are tightened (c.f. Wynne, 1978). Since energy infusion from the outside becomes less possible, minimal internal resources are mustered repeatedly to maintain stability. Each family has a comfortable strategy for problem solving. In the case of dysfunctional families, the coping mechanism becomes less viable over time because there exists less flexibility for even minor alterations. Much like the neurotic individual who

engages in self-defeating behavior, this family uses a coping mechanism which reduces tension without necessarily relieving the underlying problem.

As time progresses, the system becomes more dysfunctional, moving ever more closely toward complete paralysis. Sadly, success for such a family is often defined as a marginal existence which can lead to the development of another generation of psychosocial casualties.

The Clinician as Caretaker or, Keeping It All in the Family

The increasingly restrictive stance taken over time by dysfunctional families could not succeed in most cases without collusion from professional service providers. Debilitating relationship patterns engender attention and support (money, clothing, food, psychotherapy, etc.) from outside sources. Often, aid is given without any expectation that change can occur, and, as such, can be interpreted as official validation of the family's self-perception (c.f. Bowen's (1965b) family projection process).

Treatment aimed only at crisis intervention, i.e., helping the family to weather periodic storms in the hope that they will return to their pre-crisis condition, not only sanctions the dysfunctional homeostatic mechanism, but also gives a clear message that basic system change is most unlikely. The metamessage to the family becomes: "Further change is unnecessary. Your strategy is correct."[4] If this outcome occurs a sufficient number of times,

neither family members nor treatment providers can believe that other options exist. When the belief systems of both family and therapist merge in this direction, the therapist becomes one of the family.

The Family Therapist as Change Agent

In order to create an environment conducive to change, the therapist must demonstrate those same qualities that dysfunctional families need to develop. If the therapist shows flexibility, then there is an increased likelihood that the family members in treatment might risk more flexibility. We attempt to maintain an appropriate therapeutic stance by (a) seeing the family conjointly, (b) surrendering the belief that no change is possible, (c) taking risks, (d) developing creative interventions, (e) allowing families to maintain some symptoms, (f) working with resistance rather than against it, (g) engaging the strongest family members to initiate change, and (h) accepting less than a total cure. These conditions for conducting therapy are discussed in detail below.

Seeing the Family Conjointly

Very often the chronic family will simultaneously have many members in therapy with different professionals at different settings. Seeking help from many agencies is a wise maneuver for obtaining maximum support; however, such tactics also produce maximum confusion. The decision of who is seen where is determined not only by the family, but also by professionals outside the family constellation. The choice of agency and service provider may be determined by who

is first disturbed by a symptom (Bredemeier, 1964). The term "divide and conquer" best fits this situation; however, here the family divides to conquer the therapist, not vice versa. Since we are defining the chronic condition as a chronic family issue, conjoint family therapy is warranted. Unless the major components of the family are participants in the same therapy, the possibilities for system change are greatly diminished.

Believing that Change is Possible

When therapists view a situation as hopeless, they clearly communicate this attitude to the family. Little prospect for change can be envisioned in this circumstance. Most often the chronic family enters therapy assuming that nothing useful will occur. Such a belief is understandable given the likelihood that this "therapeutic" experience is not their first. Past therapists have given up on them, and seeking treatment has proved to be a penalty which must be paid in order to retain institutional support.

Some keys to success are perserverance, selecting goals which are attainable (no matter how small), and redefining behavior in a way which makes any change an accomplishment and turns failure into success. For example, if a couple comes to their session reporting that they were alone together only once during the week instead of the prescribed 15 minute daily appointments, one could respond: "I'm surprised you were able to be alone at all given the severity of your problems. You did better than I expected." If the people were never alone, one could respond: "I appreciate

your telling me how difficult it is for you to be together." In these situations, the people arrive expecting to be castigated for non-compliance and primed either to defend themselves, attack each other, or feel miserable for their failure. Responses like the ones offered above, if not presented sarcastically, serve two purposes: (1) The therapist is not trapped into berating the family, a tactical error which then allows the people to join forces against the outsider (by either attacking the therapist or each other); and (2) The family is thrown off-guard, allowing the therapist to move gracefully to more fertile ground.

Taking Risks and Trusting People

If one believes others have the potential for controlling their own lives, then they should be given the option to do so. Our suggestion is to put less effort into protecting people, and to expend more energy into letting them go. In therapy, trust and risk-taking create situations which allow the unexpected to occur. The therapist must bear the discomfort of not knowing how families will use this freedom. Here are a few common traps for therapists: "pushing a schizophrenic too hard will cause decompensation", "expecting too much from an alcoholic family will lead to drinking", and "making a violent man angry will lead him to beat his wife." Such therapist beliefs are destructive and counterproductive to change.

Thoughtful planning is necessary in therapy before strategic moves are made. However, we question a strategy which allows

therapeutic responsibility to burden the family with additional restrictions beyond those they impose on themselves. Below are some case examples of what we consider taking a risk:

A middle-aged couple were in treatment because of the husband's extreme jealousy. When on occasion he appeared nearly psychotic, his jealousy took the form of a delusional system in which the Church was taking his wife away from him. At the height of his distress he was bothered by ideas that ministers were attempting to seduce her. Although his fear of losing his only support, his wife, led him to suggest using violence if necessary to protect her, we did not suggest the couple forego their trip to an upcoming religious convention. This decision was taken after assessing the strengths possessed by the man and the knowledge that physical violence had never been used in the past in periods of extreme distress.

We surmised that this man had had periodic psychotic episodes throughout his adult life. These episodes were defined by the couple as occasional seizures. At this time delusions were being used as a mechanism to restrict his interaction with the outside world and protect him from reminders of vulnerability. Our decision concerning the trip was made in an effort not to lend sanction to such behavior. The couple went to the convention and returned without incident.

Another couple who, with their children, had lived for over 15 years in a rural, isolated setting, were seen for over a year. The husband was quite hostile and depressed. He often beat his wife over her imagined transgressions, and spent much of his time ruminating over past grievances with the army. He could appear frightening in therapy; when upset, he would become stiff and turn beet red. Anger had been for years his only successful tool in controlling environmental pressures--including past therapists. Upon reaching an impasse in treatment, we discussed with him how frightened he made us, and offered him a choice: we could continue to treat him gingerly with the likelihood that he would not improve, or we could approach him like a normal person with hope that his life could be better. His choice would determine whether we would walk on eggshells or confront his illogical behaviors. He chose to control his anger, and be treated no differently from anyone else. Our work then proceeded with positive results.

In another family, an alcoholic father was just discharged from an inpatient alcohol treatment program. We verbally recognized that this time was most dangerous for this family. We expected that all the people would be on edge. We stated that the alcoholic would have to prove himself again, that the family would challenge his ability to remain sober, and that our goal was to help them make the changes necessary to live a successful life. At this point we began to push and reopen old wounds. Our approach of

dealing directly with issues of intimacy gave the family permission and support to move beyond the fears which had allowed alcohol to become a tool for maintaining distance.

Developing Creative Interventions: The Ability to Do the Unusual

The foundation of a chronic family system appears to be composed of cement. The people are wrapped within a cocoon of habitual response sets; receptivity of communication from extrafamily sources is filtered out. As a result, the people inaccurately hear what the therapist says. Creating an atmosphere conducive to change necessitates restored hearing. Thus it is sometimes necessary to do the unexpected to gain attention. For example, in one of our families the husband was described as always sitting in a corner at home. He acted as if he did not wish to interact with others in the family; yet he loudly complained when people left him out of family decisions. In therapy sessions he was alternately withdrawn or argumentative. When anxious, he would produce an assortment of uncontrollable facial grimaces. We responded by acting out the home situation, placing his chair in the corner of the therapy room and asking him to face the wall. We then carried out the session with him in the corner. At one point the therapist sat back to back with him to get a "better feel for living with a man who is always turned away." After 15 minutes, the man asked to join the family, and followed up the session by making an active, honest attempt to remove himself from the corner at home.

Leaving the Family with Some Symptoms

A family with chronic problems uses tired, ineffectual coping strategies. Members either are not aware of other options or believe that other options would not work for them. Since these people possess low self-esteem, it should not be surprising that they would resist giving up the symptoms which have maintained some stability for so many years. We avoid, if possible, giving the impression that we wish all at once to strip the family bare of these supports. We reassure them that change may not come quickly, warn against trying too hard too fast, comment on some of the beneficial aspects of symptoms, and in some cases prescribe the symptom itself. For example, one might tell a withdrawn person not to try to be too active, while at the same time ask the others not to push him/her to talk during the week. Such paradoxical statements work to allay fear, but at the same time continue to exert pressure to change.

Working with Resistance

Pushing against resistance is often a fruitless task. The therapist who chooses to contest family resistance is choosing to fight a battle on the family's home territory. One is usually more successful by being innovative, moving with the flow rather than against it. For example, we had considerable difficulty influencing a couple who lived on a rural acreage. The husband, who carried the diagnosis of a paranoid personality, would not allow

his wife the freedom to interact with outsiders on any consistent, long term basis. Any suggestion that she develop interests outside the home were met by his angry outbursts. In an effort to impact upon this highly restrictive life style, we told him that she was a very insecure person, unable to change on her own. She would need his strength and support to do what was necessary for herself. He was then asked to take her to the nearest vocational training school and enroll her in a course. A class in flower arranging was selected because it met two important criteria: first, it was of interest to her; second, such an activity was nonthreatening to him. He was warned that she might become scared and try to skip classes; in such an eventuality, he was to use all of his power to ensure that she reached class by the scheduled hour. He concurred with our interpretation and agreed to follow the instructions. Both felt positive about the results (she did attend as directed), and this success became an important turning point in therapy.

Our definition of the situation as described to the couple was in many ways correct: an isolated life with few requirements did meet many of the needs of a passive woman. However, it was also a reality that half-hearted attempts made prior to therapy had been prematurely terminated by accusations and physical abuse. We felt that our approach was necessary to protect her from harm while at the same time encouraging her growth.

In cases where nothing seems to work, we invoke therapist's fallibility (Pallazoli, 1978), proclaiming that we made a mistake

by pushing too hard, too fast. We then advise the people to slow down. If resistance is manifested by missing appointments, we may schedule sessions farther apart.

In general, then, we try not to beat people over the head with their failures. We attempt if at all possible to avoid pushing against family energy. Chronic families excell in at least one area--fending off attacks from outsiders. Challenging this strength in a direct manner will more than likely result in the therapist feeling inadequate and angry. The family can then say: "We told you so. We are hopeless."

Go with the Strength in the Family

In most families one finds at least one person who demonstrates some potential for change. We have found it more productive to concentrate efforts on such people, i.e., to utilize the strength in the family rather than push against those who at first glance appear unbendable. A family is a system bound tightly together: movement demonstrated by one person will likely cause a reaction in others. Hopefully, the reaction will be positive. For example, it is not uncommon for a couple to appear for treatment of one person's symptoms. If the symptomatic individual shows little desire to change, we focus on the healthier spouse (often the one expressing distress) in hopes that the other will feel impelled to follow.

For example, an elderly woman complained bitterly about being unable to enjoy retirement because of her involutionally depressed

husband. We emphasized how she let his symptoms rule her life. An effort was then made to induce her to make her own life more active, regardless of her husband's fears. She did as instructed, and he followed her. He currently remains anxious and ruminative, but is doing so while chasing after her.

In the case of a retired Puerto Rican couple, where the husband had been disabled for 15 years due to mental disorders, one result of therapy was the wife's learning that her husband might never give her much intimacy and support. He had never done so in the past. She was encouraged to seek support from others and did so by finding companionship at a Spanish speaking senior citizens center. The husband, who disliked being alone, followed her. Both are now engaged in center activities.

A 33-year-old woman brought in her chronically paranoid schizophrenic father, her passive, frightened mother, and her 30-year-old retarded brother. Her parents and brother lived a secluded life, rarely leaving their house. The mother and son stayed home ostensibly to avoid hearing the father's delusional accusations about what they might have been doing while away. They were thus controlled by his irrational thoughts. The daughter, who lived apart from them with her own child, had been shepherding the others for years, acting as their go-between with the world. She wrote their checks, balanced their checkbook, arranged doctor appointments, etc. The three people she watched over were frightened individuals who derived

comfort from being protected. We quickly decided that the first step in therapy should be to remove this daughter from her role as savior. This tack made sense not only because it was a necessary prerequisite for forcing the others to stand on their own feet, but also because the young woman was tired of her responsibility. We started by having her give up balancing the checkbook and encouraged her to gradually stop assuming responsibility for the others' well being. Within six weeks her only contact with them was a weekly social visit. We then reinforced her desire to quit family therapy. After this move, we concentrated on breaking the myths preventing the other three from leaving their house.

They gradually increased time away from each other. The mother was the first object of this effort. She was encouraged to visit her relatives for a day or two, leaving her husband and son alone. When her absence was accepted, we began concentrating on the son. At the time therapy was terminated, the mother was working at a day care center, the father was working as a clean-up man at an auto dealership, and the son was making visits to extended family. Most of the father's delusional utterances had long ceased. Unfortunately, the son's efforts to find employment through vocational rehabilitation were abandoned when his caseworker told him he would lose social security benefits if training were attempted and a job were secured.

Accept Less than Total Change

Chronically disturbed families, like everyone else, usually come for help in times of unusually high distress. At these times the therapist has an opportunity to effect change because the system is somewhat destabilized. However, when the crisis recedes, often so does the family's motivation to attend sessions. One can attempt to fight against this natural tendency, but such a struggle often ends with their failure to appear for scheduled sessions, bad feelings, and perhaps a lessened likelihood that these people would feel comfortable returning when the next crisis occurs. If all reasonable efforts fail, including placing the family on a less frequent schedule, one should allow them to terminate gracefully. This manuever allows both sides to feel good about their accomplishments, no matter how small, and lays the foundation for future work.

Conclusion

To summarize, we find family therapy particularly well-suited to the task of improving the functioning of chronically emotionally impaired adults. Conjoint therapy is indicated due to the rigidity of coping strategies which these families have developed over time. Unfortunately, members of the dysfunctional family are frequently in contact with multiple service agencies. Such involvement tends to reinforce and maintain the dysfunctional system.

With increasing numbers of chronically impaired adults being maintained at home with the use of psychotropic medications and

financial aid, their families and mental health professionals are faced with new challenges. We submit that therapists' negative attitudes toward these families must be modified to include increased expectation of change as a first step toward effecting improvement. In addition, the ability to take risks, develop creative strategies and set realistic goals is required. We are encouraged and on occasion, pleasantly surprised by our efforts with this population and encourage the development of new techniques from other family therapists.

References

Bateson, G., Jackson, D., Haley, J., & Weakland, J. Toward a theory of schizophrenia. Behavioral Science, 1956, 1, 251-264.

Becker, H. Outsiders. New York: Free Press, 1963.

Bowen, M. Family relationships in schizophrenia. In A. Auerback (Ed.), Schizophrenia: an integrated approach. New York: Ronald Press, 1959, 147-178.

Bowen, M. A family concept of schizophrenia. In D. Jackson (Ed.), The etiology of schizophrenia. New York: Basic Books, 1960, 346-370.

Bowen, M. Intrafamily dynamics in emotional illness. In A. D'Agostino (Ed.), Family, church, and community. New York: Kennedy & Sons, 1965a, 81-97.

Bowen, M. Family psychotherapy with schizophrenia in the hospital and private practice. In I. Borzormenyi-Nagy & J. Framo (Eds.), Intensive psychotherapy. New York: Harper & Row, 1965b, 213-243.

Bredemeier, H. C. The socially handicapped and the agencies: A market analysis. In F. Reissman, J. Cohen, & A. Pearls (Eds.), Mental health of the poor. New York: Free Press, 1964, 88-109.

Goffman, I. The presentation of self in everyday life. Garden City, New York: Anchor Books, 1959.

Goldman, H., Gattozi, A., & Taube, C. A. Defining and counting the chronically mentally ill. Hospital and Community Psychiatry, 1981, 32, 21-25.

Hurvitz, N. Psychotherapy as a means of social control. Journal of Consulting and Clinical Psychology, 1973, 40, 232-239.

Jackson, D. Guilt and the control of pleasure in schizoid personalities. The British Journal of Medical Psychology, 1958, 31, 124-130.

Kempler, W. Principles of gestalt family therapy. Salt Lake City: Deseret Press, 1974.

Lamb, H., & Oliphant, E. Schizophrenia through the eyes of the families. Hospital and Community Psychiatry, 1978, 29, 803-806.

Lidz, T. The family and human adaptation. London: Hogarth, 1964.

Meehl, P. E. Schizotaxia, schizotypy, and schizophrenia. American Psychologist, 1962, 17, 827-838.

Mishler, E., & Waxler, N. (Eds.). Family process and schizophrenia. New York: Science House, 1968.

Palazzoli, M., Cecchin, G., Prata, G., & Boscolo, L. Paradox and counterparadox. New York: Jason Aronson, 1978.

Scheff, T. The societal reaction to deviance: ascriptive elements in the psychiatric screening of mental patients in a midwestern state hospital. Social Problems, 1964, 401-413.

Scheff, T. Being mentally ill: a sociological study. Chicago: Aldine, 1966.

Szasz, T. The myth of mental illness. New York: Delta Books, 1961.

von Bertalanfy, L. General system theory in psychiatry. In S. Arieti (Ed.), American handbook of psychiatry. New York: Basic Books, 1974, 1095-1117.

Wynne, L. Knotted relationships, communication deviances, and metabinding. In M. Berger (Ed.), Beyond the double bind. New York: Bruner/Mazel, 1978, 177-188.

Footnotes

[1]The effects of this change on the families of chronically disturbed persons are poignantly presented by Lamb, H. R., & Oliphant, E., 1978.

[2]The number and location of the chronically mentally ill in the community are discussed by Goldman, H. H., Gattozi, A. A., & Taube, C. A., 1981.

[3]The term "grossly inadequate family" refers to the general level of adaptation and cuts across psychiatric diagnoses.

[4]See Becker (1963), Bredemeier (1964), Goffman (1959), Hurvitz (1973), and Scheff (1966) for in-depth explorations of the social implications of this statement.